MENTAL HEALTH PLAN

CALIFORNIA DEPARTMENT OF CORRECTIONS & REHABILITATION
DIVISION OF JUVENILE JUSTICE

Farrell v. Hickman

Mental Health Remedial Plan

November 30, 2005

TABLE OF CONTENTS

I. OVERVIEW

The Mental Health section of the Consent Decree Remediation Plan is in response to fifteen areas of concern identified in the findings and recommendations of the "Report of Findings of Mental Health and Substance Abuse Treatment Services to Youth in California Department of Corrections and Rehabilitation Facilities", December 2003.

The Youth Authority Act established the purpose of the California Department of Corrections and Rehabilitation – now titled the Division of Juvenile Justice (DJJ) of the California Department of Corrections and Rehabilitation (CDCR) – to protect society by providing treatment and training directed toward the correction and rehabilitation of youth who have committed public offenses (Welfare and Institutions (W&I) Code 1700).

The Division of Juvenile Justice (DJJ) is in the process of developing and implementing a reorganized Health Care Services Delivery System (HCSDS). The provision of mental health services is under the umbrella of this system, a model that includes the guiding concepts of: centralized medical leadership, standardized policy and procedures that conform with acceptable national standards of care, a system of auditing procedures and a program for fostering linkages to university-based programs, public health agencies and aftercare services, and agencies to which our youth transfer. The Health Care Services (HCS) Medical Remedial plan addresses the findings of the medical experts and presents the organizational structure for the leadership and authority within the HCS.

The developing Integrated Treatment Delivery of Care System (ITDCS) for mental health is designed to provide, in conjunction with standard policy and procedures, a comprehensive guideline for the delivery of appropriate services for the mental health and rehabilitation needs of all youth. The system initiates during the court referral process, expands at a youth's initial entry into a DJJ reception center and clinic, progresses through the core program services, and finally allows for transitioning to parole and aftercare services (see Figure 1). This system of care will be supplemented by services provided within health care, education and those being developed within the Programmatic Model. The new model, detailed in the Safety and Welfare Plan, aims at reducing recidivism through, among other components: a strong classification system, risk/needs assessments, evidence-based rehabilitative programs, appropriate facility/program placement, targets for intervention (risks/strengths), treatment planning through the Individual Change and Accountability Plan (ICAP), family involvement and transition planning.

The following are key principles that are part of the foundation of the ITDCS:

1. Providing access to the appropriate level of care to all youth, one that is a client focused model that recognizes that the needs of youth change over time, is essential. The treatment of youth with mental disorders allows the DJJ to further its mission of rehabilitation by providing a system of care that provides timely and appropriate screening and assessment, mental health and other specific treatment services (sex

behavior treatment, substance and alcohol abuse, etc.) and transition planning in a coordinated and integrated system.

2. Identifying and treating symptoms of mental illness, utilizing specific treatment plans and evidence-based treatment interventions and programs that are cognitive-based and focused on skill development, will allow youth to participate in rehabilitative services not only aimed at reducing criminogenic behaviors and attitudes, but which will ultimately produce healthier, productive members of the community.

3. Emphasis upon individual responsibility and accountability is an important aspect of good mental health treatment and rehabilitative services. A mental disorder does not excuse a youth from individual responsibility and accountability for choices. While there are important exceptions to this general principle for the most disturbed youth, mental health and rehabilitative services are delivered to assist youth in assuming increasing responsibility for their decisions/behaviors. The youth's ability to achieve his/her treatment goals is supported by a therapeutic emphasis on responsibility for one's own behavior through skill enhancement, which focuses on recognizing the strengths of the individual and developing skills where there are deficits.

4. Family involvement is essential for appropriate assessment, to support treatment progress and for transition planning and reintegration. Placing youth close to family or guardians, whenever possible, is a basic principle of the system.

5. Standardization of mental health policies and development of local procedures, a therapeutic approach to servicing all youth, increased staffing and training, coordinated service delivery, and documentation are key elements to this model. The consistent utilization of evidence-based treatment interventions (or "best practices and emerging fields") that are developed, monitored and tracked through consistent reassessment of both individual and program progress, will improve the quality of care for all youth.

The attached chart of the ITDCS (Figure 1) represents the system's approach to delivering mental health and rehabilitative services. Currently, the department provides screening, assessment and classification services at the reception centers and clinics. The plan will include the implementation of new and innovative mental health screening and specific assessment for cognitive disabilities, and also identifies more specifically the use of the Special Program Assessment Needs (SPAN), which was in development at the time of the expert's initial assessment. Classification is addressed within the Safety and Welfare Plan of the Consent Decree and includes components that will impact youth with mental health issues.

Certain program components have been added since the initial expert report, including Cognitive Behavioral Treatment (CBT) based interactive journals, the Individual Change Plan (or ICP – a treatment plan format which is currently in use and will be further developed into the Individual Change and Accountability Plan as described in the Safety and Welfare Plan), and the opening of the Intermediate Care Facility run by the Department of Mental Health at the Southern Youth Correctional Reception Center and Clinic. Future components to the Integrated Treatment Delivery of Care System (ITDCS) include the opening of the Southern Correctional Treatment

Center, the development of several community-based service contracts for acute level of care services in several counties, and the expansion of mental health and rehabilitative services division-wide to ensure all components and services required to meet the needs of the youth are available.

The following is a brief description of each section of the chart, which will also be expanded on in the development of the Integrated Treatment Delivery of Care System.

Entry to the Division of Juvenile Justice (DJJ) - through the intake and court services process occurs within the acceptance process from the counties, the reception center and clinic process which includes integrated screening and assessment involving medical, dental, mental health and educational need, the DJJ orientation process and completion of the individual's risk and need classification.

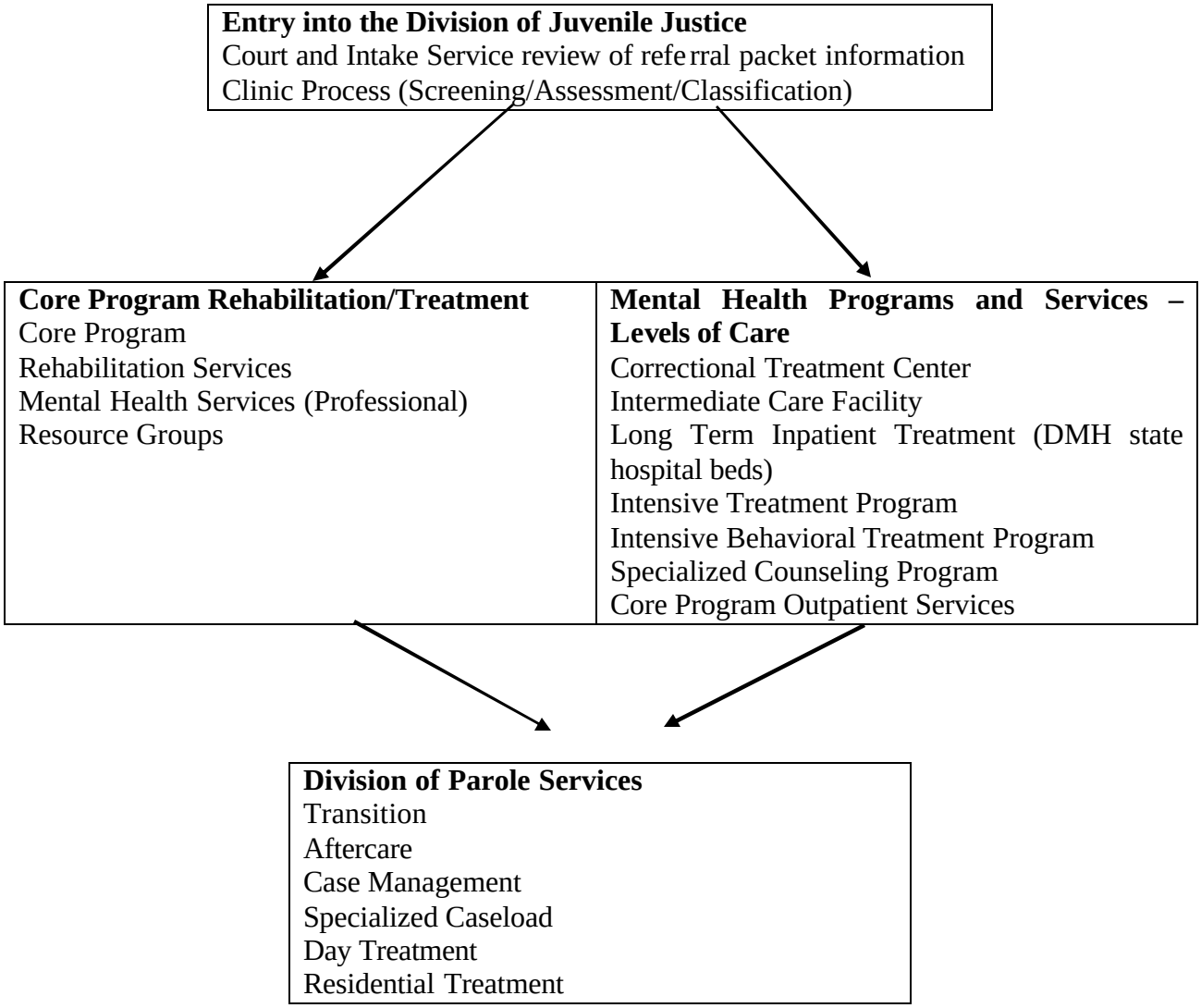
Core Program Outpatient Services (CPOS) - is the lowest level of care, the level where a significant percentage of youth in the division are classified. Mental health professionals working in this level of care will be involved in providing mental health screenings and assessments, more intensive mental health needs assessments and evaluations, crisis intervention, administrative duties (Board of Parole and Administrative Committee hearings), individual and group therapy, attending Case Conferences, treatment planning, report writing, etc. If this is the identified level of care after completion of the screening/assessment and classification process, youth will receive rehabilitative services suited to their risk level and needs and have mental health services available as the need arises.

At this time, a major component of the rehabilitative services center on the Interactive Journals of the Core Program, based on the Trans-theoretical Model of Change, Cognitive Behavioral Therapy (CBT) and Motivational Interviewing techniques. Currently, most rehabilitative services for this population are provided to the youth on their assigned living units by the assigned Youth Correctional Counselor. When a youth is identified through on-going review and assessment, to be in need of specific mental health resources to address an Identified Treatment Issue (ITI), the "Intensive Needs Journals" will be assigned. These interactive journals will replace previous "Board-ordered" counseling, and will be delivered by mental health professionals. The Safety and Welfare Remedial Plan will outline the enhancement of services to all youth, regardless of their level of care, with specific detail given to overall program, transition, risk/need assessments, etc.

Mental Health – The Levels of Care identified are the mental health treatment programs and services designed to address the needs of youth with specific mental health needs in a residential setting. These levels of care provide mental health staff with the ability to utilize a "step-up and step-down" process for the fluctuating needs of these youth, ranging from 24 hour, acute, licensed care to long-term care in a state hospital setting, or residential care within the facilities to Core Program Outpatient Services (CPOS) while residing in the Core Program. This provides the ITDCS the opportunity to place youth in the appropriate placement, with adequate services, in a more systematic and fluid manner.

The development of the treatment guidelines for each level of care will be outlined in more detail in the development of Program Guides for each level of care, including the type, frequency and staff classification providing direct services in each mental health program. The Mental Health Expert will be involved in the development of treatment standards, and will assist in integrating changes brought on by the development of new assessment protocols and treatment activities. Drafts for the Program Guides are complete at this time, and will be updated and implemented as mental health processes and services are finalized and as resources to implement these are available. Members of the Interdisciplinary Treatment Team (IDTT) assigned to these programs will be involved in providing a standard of direct service hours, case management, individualized treatment planning, on-going assessment, crisis intervention, in-service training of non-professional staff, family work, transition and aftercare planning, preparing referrals, Board of Parole and Administrative Committee hearings, attending case conferences, report writing, etc.

INTEGRATED TREATMENT DELIVERY OF CARE SYSTEM
(ITDCS)



(Figure 1)

II. PROGRAM STATEMENT

The mission of the Division of Juvenile Justice (DJJ), Health Care Services Delivery System (HCSDS) is to provide access to care, quality of care and continuity of care to youth in the DJJ while preparing them to return to their communities as contributing and healthier individuals, through skill enhancement and improved motivation with regard to their physical and mental health, education and vocational goals, family interactions and transitional services.

To ensure the realization of the mission, the following goals have been identified as the priority of the HCS mental health services:

ACCESS TO CARE
Ensure all youth have access to care to meet their health care needs as identified by health and mental health care professionals.

STANDARDIZATION
Identification and implementation of nationally accepted standards in health services focused on improving the health of youth, the efficacy of mental health services provided, and the Agency infrastructure.

EVIDENCE-BASED TREATMENT
The utilization of treatment services and modalities which identify objective, outcome measures based on specific treatment services, with clearly defined compliance indicators and comprehensive and integrated guidelines within which treatment occurs.

EXPANSION OF TREATMENT SERVICES
Continue to pursue resources required to: provide comprehensive mental health services on a continuum of care model; identify and appropriately treat youth with co-occurring disorders; maintain on-going involvement of families/guardians in assessment, service provision and transition planning and identify emerging and promising treatment modalities.

EXPANSION OF TRANSITION SERVICES
Ensure that adequate resources are available to provide information regarding supportive mental health services to youth and, when available, their families to facilitate successful reintegration into the community.

The HCS will develop and rely on the following functions to reach these goals:

PROGRAM MONITORING AND EVALUATION
Provide for on-going quality screening, assessment and improvement of the mental health delivery system and treatment programs by utilizing Continuous Quality Improvement and a Quality Assurance and Peer Review process.

COMMUNICATION NETWORK AND DATABASE
Maintain accurate, comprehensive data on all mental health clients and services, and make that information readily available to clinicians and case managers who need it.

SCREENING, ASSESSMENT AND CLASSIFICATION
Accurately identify the mental health services client population and the specific mental health needs of the individuals within that population through appropriate, thorough and timely screening, assessment, and placement in the appropriate level of care.

ADMINISTRATION OVERSIGHT AND ACCOUNTABILITY
Provide an infrastructure for service delivery, program development, quality improvement and clinical oversight through the creation of a centralized, formal organization system and staffing pattern.

PROFESSIONALISM/TRAINING
Assure that mental health services are provided by suitably credentialed, trained, and experienced mental health professionals (psychiatrists, psychologists, social workers, psychiatric technicians, etc.). And, assure that rehabilitative services are provided by staff that is properly trained in the rehabilitative program model.

DISCHARGE PLANNING
Develop and provide coordinated treatment plans when release is imminent for youth with mental health issues that include a consultation with family/guardians when available, a sufficient supply of medications, referrals to community health care providers and follow-up services.

III. DEFINITIONS

ORGANIZATIONAL LEADERSHIP

TRANSITION TEAM

The Transition Team is the group of individuals selected to develop a new system of juvenile and adolescent health care to transition from one system of care to another. A Mental Health Subgroup was identified to address the Mental Health Remedial Plan. The Transition Team is tasked with finalizing a Medical Remedial plan that was to be submitted to the Court by September 1, 2005, as well as the Mental Health Plan by November 30, 2005. The Transition Team shall serve as an ad hoc committee with a specific purpose of developing and implementing the provisions of the health care services remedial plan.

HEALTH AUTHORITY

The health authority is the person who is the final and ultimate authority for making clinical and programmatic decisions regarding health care services for the youths of the CDCR. This person shall be the Medical Director.

AUTHORITY

The authority for the establishment and operation of the California Department of Corrections and Rehabilitation, Division of Juvenile Facilities (CDCR), and the appointment of the Chief Deputy Secretary for Juvenile Justice is set forth in Division 2.5, Chapter 1, Section 1700 et. seq. of the Welfare and Institutions Code. The Chief Deputy Secretary for Juvenile Justice is authorized to make and enforce all rules proper to the accomplishment of the functions of the Division of Juvenile Facilities, including those related to the medical, surgical, dental, and mental health needs of youth lawfully committed to the CDCR.

MENTAL HEALTH POLICY, PROCEDURE, AND PROCESSES

ACCESS TO CARE

All youth shall be provided the opportunity to report an illness, injury, or any other health concern whenever and wherever one occurs. Health care requests are made in written or verbal form (documented by the staff receiving the verbal request and forwarded to the appropriate medical and/or mental health staff). Treatment will be delivered according to the youth's current level of care (LOC) or higher if required.

CASE MANAGEMENT

Case management is the coordinated efforts and monitoring system of all basic rehabilitative/treatment and educational services developed with the youth and documented in the Individual Change Plan (ICP). Case management also fosters communication between mental health professionals, educators, custodial staff, family and/or guardians. In addition, this process establishes a transition plan when the youth moves within the system and also when returning to the community. **The ICP is being modified to include components of the new program model, and will be titled the Individual Change and Accountability Plan (ICAP).* The

ICAP will incorporate all rehabilitative and treatment plan components defined in this plan and the Safety and Welfare Plan.

CONTINUM OF CARE

The continuum of care model assumes that the treatment needs of a youth may change over time, so the delivery of care system should be flexible enough to both continuously assess these changing needs and provide various levels of treatment that match the needs of the youth. The continuum consists of several levels of care that provide varying levels of treatment, linked together in a manner that provides for step-down and step-up opportunities based upon identified need. More intensive levels of treatment generally correlate with more hours of treatment services per day or per week.

IDENTIFIED TREATMENT ISSUES (ITI)

Currently, Identified Treatment Issues (ITI) are developed at the reception centers and clinics, documented on the Individual Change Plan (ICP) and reviewed at the Initial Case Review (ICR). The basis of the ITI could generate from areas such as the youth's criminal history, family background, history of trauma and mental health issues, current mental health symptoms/conditions, medical history, current medical symptoms/ conditions and educational needs. To maintain confidentiality of the youth's medical and/or mental health diagnosis, only the Mental Health Treatment Plan shall document specifics in these areas. The ITI should be written and framed from a strength-based perspective, with youth and family (when applicable) involvement in the development of these treatment issues.

INDIVIDUAL CHANGE PLAN (ICP)

The Individual Change Plan (ICP) currently forms the basis of the youth's treatment as he/she progresses from the reception center and clinic, to the assigned facility and out to parole in the community. The ICP represents the youth's basic treatment plan. As mentioned above, this will be replaced by the Individual Change and Accountability Plan (ICAP). Youth receiving mental health services will modifications made to their plans, specifically identifying the services, goals and processes to reach them. Certain aspects of this plan will be placed in the medical record and will be available for viewing by non-medical staff on an as needed basis.

INITIAL CASE REVIEW (ICR)

Within 45 days of arrival at a reception center and clinic, all new commitments have an Initial Case Review (ICR). At the ICR members of the Interdisciplinary Treatment Team (IDTT) review the Individual Change Plan (ICP) developed for the youth by the assigned case manager. The ICR includes among other things, a review of the youth's treatment needs and criminogenic factors, the need for further screenings and evaluations, the results of the risk assessment, as well as a review of the High School Graduation Plan. The completion of the ICP, Part I (identification of initial treatment goals), is also a function of the ICR. Changes to this process are outlined in the Safety and Welfare Plan.

LEVEL OF CARE (LOC)

The concept of "level of care" involves a hierarchy of treatment levels of varying intensity. High levels of care involve 24-hour nursing care (acute) at inpatient (hospital) settings with enriched staffing. Residential mental health programs are staffed with an IDTT comprised of mental

health, custody, education, and vocational staff, who provide mental health treatment plan driven services. Lower levels of care involve a case management approach to treatment that generally provides periodic contacts with youth with mental health issues who are relatively stable, but could benefit from occasional mental health contacts utilizing Intensive Needs Journals, individual or group therapy. The varying levels of care offer each youth "step-down" and "step-up" opportunities so that treatment can be customized to meet the fluctuations in mental status (improvement or deterioration).

MENTAL HEALTH WARD DESIGNATION

A process of review that identifies the presence of specific emergent clinical risk criteria, leading to a youth being designated and documented as currently (or possibly in the future) requiring mental health services. These risk criteria are defined to generally include recent placement on suicide watch, being classified as High Risk for suicide, pending placement on a mental health program, being prescribed psychotropic medication and exhibiting moderate to severe symptoms of psychological dysfunction or distress.

SPECIALIZED MENTAL HEALTH ASSESSMENT

Specialized mental health assessments are designed to accurately diagnose mental illness, substance abuse disorders, developmental disabilities and learning disorders. These assessments consist of structured psychiatric evaluations, mental status examinations and standardized cognitive and psychological assessment. These assessments will allow a clinician to identify and confirm a diagnosis, identify the degree of functional impairment, and develop a proposed strategy for treatment.

SUICIDE PREVENTION ASSESSMENT AND RESPONSE

The Suicide Prevention Assessment and Response (SPAR) policy is designed to prevent suicides through a standardized approach of assessing youth for risk factors during periods of stress or when the youth's words or behavior indicates he/she may be at risk. In addition to assessment, SPAR mandates, among other things, appropriate documentation, communication, timeframes for clinical contacts and the expectations of custody staff. The suicide prevention program includes mandated training of staff with a schedule for on-going training.

TREATMENT NEEDS ASSESSMENT

The Treatment Needs Assessment (TNA) is a psychological screening process that was developed to determine the need for mental health, cognitive and substance abuse interventions and programs among incoming (and returning) youth. The Treatment Needs Assessment consists of a battery of standardized, self-report psychological screening instruments (Weinberger Adjustment Inventory (WAI), Massachusetts Youth Screening Instrument (MAYSI) and Youth Self-Report (YSR – Achenbach and Drug Experience Questionnaire (DEQ), which are currently administered to all incoming youth in a systematic and uniform manner. These instruments are designed to raise FLAGS in such areas as suicide risk, violence potential, mental health issues and substance abuse problems.

TREATMENT PLANNING

Treatment planning is the process of identifying the treatment needs and developing a plan to intervene in addressing a youth's mental health symptoms and emotional needs. Treatment plans

will be specific and measurable, with specific evidence-based treatment modalities and interventions utilized to accomplish these goals identified, e.g. Dialectical Behavior Therapy (DBT), Self-Management Therapy, Cognitive Behavioral Therapy (CBT), Aggression Replacement Therapy (ART), and Social Skills Training. Youth with co-occurring disorders will have this clearly identified on the treatment plan, and treatment services will reflect the appropriate timing and type of services.

UNIFIED HEALTH RECORD

A Unified Health Record (UHR) will be initiated for every youth admitted to the DJJ. Using this standard departmentally approved document, staff will maintain a current record of treatment plans, progress notes, and other medical, dental, mental health, and public health information. All medical forms at all facilities are subject to approval by the Clinical Record Administrator in Health Care Services. Policies and procedures regarding the format and contents of the record, disclosure of confidential medical information, transfer of records, and record retention will be promulgated by Health Care Services.

LEVELS OF CARE

CORRECTIONAL TREATMENT CENTER (CTC)

The Correctional Treatment Center (CTC) is a health facility licensed by the Department of Health Services (DHS) under Title 22 Chapter 12 of the California Code of Regulations (CCR). The CTC has a specified number of licensed beds located within a DJJ facility. This level of care is designated to provide health care to that portion of the youth population who do not require a general acute care level of services but are in need of professionally supervised health care beyond that normally provided in the community on an outpatient basis.

CORE PROGRAM OUTPATIENT SERVICES (CPOS)

Core Program Outpatient Services (CPOS) provide mental health and supportive services. The CPOS mental health staff is part of the integrated treatment delivery system at each facility, and provides services based on (among other things) referrals from staff or youth, in support of behavior modification programs, as part of on-going intensive needs resource groups and/or in crisis situations, screenings and assessments, administrative hearings, individual and group therapy, etc. Youth in this level of care typically can function well in the core program with occasional problems, and can benefit from outpatient mental health and supportive services.

INTENSIVE TREATMENT PROGRAM (ITP)

The Intensive Treatment Program (ITP) provides residential mental health care. This level of care is characterized by separate living units and academic facilities (not at all facilities), and structured activities for youth with particularly severe mental illness, emotional and behavioral disorders that require a full range of psychological, psychiatric and supportive services who, because of their disorder may experience adjustment difficulties in a core program setting, yet do not require acute care in a licensed bed.

INTERMEDIATE CARE FACILITY (ICF)
The Intermediate Care Facility (ICF) provides licensed and accredited inpatient mental health services for youth that have severe and persistent mental illness. Youth referred to the program require both a secure setting and a hospital treatment environment. The goal of the program is to provide intensive, shorter-term psychiatric care that will result in stabilization of symptoms and the acquisition of skills needed to successfully function in the next disposition. The ICP provides intermediate term, crisis mental health care to youth whose condition requires an inpatient mental health care setting (24-hour nursing care) for up to (approximately) 120 days.

LONG TERM INPATIENT TREATMENT (DMH)
The Department of Mental Health contracts with the HCS to provide inpatient mental health services to youth with a major Axis I disorder, and a GAF score of 30 or less, who are unable to adequately function and stabilize within the structure of the DJJ mental health treatment programs and whose psychiatric condition can potentially be remediated and stabilized within the State Hospital treatment program.

INTENSIVE BEHAVIOR TREATMENT PROGRAM (IBTP)
The Intensive Behavior Treatment Program (IBTP) provides residential mental health care. This level of care is characterized by separate living units and academic facilities, and structured activities for youth with mental illnesses who otherwise did not qualify, or were excluded from other Intensive Treatment or Specialized Counseling Programs due to extremely disruptive and violent behavior driven by a serious mental health diagnosis. The program provides intensive treatment for acutely psychotic, emotionally unstable young men with serious characterological handicaps, who, due to their acting-out and violent, disruptive behavior, are unable to function in less restrictive programs.

SPECIALIZED COUNSELING PROGRAM (SCP)
The Specialized Counseling Program (SCP) provides residential mental health care. This level of care is characterized by separate living units, some with separate academic facilities, and structured activities for youth that exhibit either acute or long-term manifestations of social and emotional disturbances at a level of severity greater than can be reasonably addressed within a core program unit. The youth are able to provide for their basic needs and have skills/abilities to participate meaningfully in structured therapeutic activities.

MENTAL HEALTH SERVICES AND PROGRAMS

CRISIS MANAGEMENT
Crisis management requires that each facility, in a consistent and well monitored manner, address, access, develop and implement plans to protect and prevent youth from engaging in behaviors which place them at risk of harm, i.e., suicide prevention program.

MANAGEMENT OF PSYCHOTROPIC MEDICATIONS
The management of psychotropic medication is conducted by either a psychiatrist or, under certain defined circumstances, non-psychiatrist physician or clinical nurse practitioner supervised by a child psychiatrist. Coordination with other providers and case managers is essential in providing treatment and consistent monitoring to address the effectiveness of reducing symptoms

and educating youth(s), staff, and family or guardians of the benefits and potential side effects of psychotropic medication. ** For more detail refer to the HSCDS Medical Remedial Plan.*

MENTAL HEALTH SERVICES

Mental health services refer to treatments provided by, or under the supervision of, qualified/licensed mental health professionals. Services are formulated from assessments, will be documented in the treatment plan/ICAP., and will be reviewed and revised as needed by the youth's Treatment Team (IDTT). Continuity of care and transition plans (documented in the ICAP) are required when a youth is transferred between facilities or is returning to the community.

MENTAL HEALTH INTERVENTION PROGRAM (MHIP)

The Mental Health Intervention Program is designed to assist in the screening and referral process for youth housed on the diagnostic units at the reception centers and clinics. It also provides mental health and supportive services for youth during their stay at the reception centers. These services are provided by both Case Managers and Youth Correctional Counselors. Youth will undergo an initial assessment within the first three working days of arrival. Referrals for more in-depth and specific psychological evaluations will be made utilizing the standardized process.

OUTPATIENT HOUSING UNIT (OHU)

An Outpatient Housing Unit (OHU) in a DJJ correctional facility shall house youths that require special housing for medical observation or protection. This will be the highest level of medical/mental health care capability on-site at DJJ facilities except where CTCs exist. Youth requiring care beyond the capabilities of the OHU will be transferred to an acute psychiatric care community hospital. DJJ Outpatient Housing Units are equivalent to infirmaries as defined in NCCHC. DJJ policies and procedures will adhere to the NCCHC Standards for Health Services in Juvenile Detention and Confinement Facilities 2004 Edition (see Reference section). One Registered Nurse shall be on-site in the outpatient housing unit a minimum of eight hours daily. The California Department of Health Services will not license an OHU.

PAROLE TRANSITION/AFTERCARE

Youth require a continuum of care to transition into the community upon leaving a facility where he/she was involved in some aspect of mental health treatment. This follow-up treatment, depending on the youth's individual needs, might involve an inpatient program, day treatment in a group home, aftercare services provided in parole offices or outpatient services in county or private agencies. Parole Agents will be provided a copy of the youth's ICAP, and will be required to meet (or at a minimum have a phone conference) with the youth and Interdisciplinary Treatment Team (IDTT) before the youth leaves the facility so that the appropriate treatment setting and services can be arranged and the ICAP can be followed while on parole.

SCREENING/INITIAL ASSESSMENT

Screenings/initial assessments are designed to identify existing and emergent mental health issues, suicide risk, psychiatric, medical, substance use, and developmental and learning disorders. Screening information will be summarized and communicated to staff through

assessment reports and written evaluations to address treatment needs, including contact with family or guardian(s) to elicit information to assist in the youth's care and treatment.

BEHAVIOR TREATMENT PROGRAM

Behavior Treatment Programs are highly structured, segregated program environments. These programs (as outlined in the Safety and Welfare Plan) provide integrated program services including counseling, education, medical and mental health services designed to address violent and disruptive behaviors in an effort to return the youth to a less restricted program environment.

IV. KEY COMPONENTS

1. Organizational Leadership

ADEQUACY OF MENTAL HEALTH CARE FACILITIES

The Division of Juvenile Justice (DJJ) is responsible for the rehabilitative treatment and training services for approximately thirty-two hundred incarcerated youthful offenders, as well as approximately thirty-two hundred seventy youth on parole supervision status. At this time, the DJJ operates eight youth correctional facilities (one a stand alone reception center and clinic) and two fire camps.

Mental health services are provided to youth in a variety of settings and at identified levels of care. The ITDCS has three distinct levels of care available at this time. Each level of care will provide a prescribed level of direct services to be delivered by a range of mental health professionals. These include:

Inpatient treatment (24-hour nursing care):

- Correctional Treatment Center (CTC)
- Intermediate Care Facility (ICF)
- Long Term Inpatient Treatment (DMH)

Residential mental health programs:

- Intensive Behavior Treatment Program (IBTP)
- Intensive Treatment Programs (ITP)
- Specialized Counseling Program (SCP)

Outpatient mental health services:

- Core Program Outpatient Services (CPOS)

Physical plants throughout the DJJ include several designs within which mental health programs are housed. The most prevalent design is the open-dormitory setting; others include single and double-occupant secure rooms. Currently, living unit occupancy can range from a total occupancy of as low as 30 to over 60, depending on facility and population needs.

The specific and unique needs of the mental health population require that consideration and resources be focused on the physical plant as an essential component of the "therapeutic milieu". Treatment issues go beyond the services provided by the mental health and custodial staff, and include where the services are provided. Concerns with suicide and safety precautions, special education, physical conditioning, organized recreational activities and on-site medical/mental health services should also be considered in decision making regarding physical plant issues.

The Integrated Treatment Delivery of Care System (ITDCS) (in conjunction with the HCSDS) will develop standardized policies and procedures for the integrated delivery of mental health services from acceptance to discharge, statewide. As program and location decisions are made

and funding resources become available, the full implementation of the services provided within the ITDCS will be phased in under the direction of HCS administrative staff.

- The newly defined Programmatic Model (as outlined in the response to the Stipulation regarding California Youth Authority Remedial Efforts filed January 31, 2005) will be developed in more detail in the Safety and Welfare Remedial Plan and is proposing increasing staff-to-youth ratios for youth in the current core program living units. Mental health programs, housing emotionally dysregulated, impulsive and higher need youth, will move to housing smaller populations in residential programs as well.

Additionally, professional and treatment space will be needed to provide services safely and confidentially. New construction of physical plants, both for "mental health clinics" or living units more suitably designed to house smaller numbers and be "self-contained" is a direction the Division of Juvenile Justice (DJJ) is committed to pursuing. The timeline for the construction and occupation of these units is not known at this time, and is under review as a component of the state's overall juvenile justice reform efforts and the Safety and Welfare Plan. Planning in this area has involved DJJ Facilities Planning staff, outside consultants with expertise in facility design, community program stakeholders, court and probation personnel, etc. When this process reaches the point where specific design features and identified populations are part of the discussion, the Mental Health Expert will work in conjunction with DJJ staff to identify the needs of the mentally ill youth and consider these needs when designing a physical environment that will support the treatment milieu and the professional needs of staff.

The process of identifying existing facilities to house these programs, and for relocating programs from one facility to another, is currently under consideration. Assigning each facility a "mission" and specific population to be served will be considered as a component of the classification system in development, using a multi-layered criteria approach that includes the mental health needs of the youth. The youth identified with mental illness will also be placed on specific programs according to risk and needs when possible, to improve the safety on mental health programs and further improve the therapeutic environment (e.g. high risk youth housed together on a mental health program, to limit low risk youth from predation and violence).

ADEQUACY OF MENTAL HEALTH PROGRAMS

The Integrated Treatment Delivery of Care System (ITDCS), under the umbrella of the Health Care Services Delivery System (HCSDS), outlines mental health and rehabilitative services available within the ITDCS. As stated previously, it is designed to provide a comprehensive system for identifying and delivering appropriate services for the treatment needs of all youth from their entry to the DJJ through parole services and discharge. Health Care Services is committed to implementing a system that screens, assesses, classifies, and treats youth with mental health needs from acceptance through parole transition.

The development of a thorough assessment protocol for youth with mental illness that includes diagnostic criteria as well as evidence-based treatment modalities proven effective is underway. The ITDCS may continue to use (at least) components of the existing assessment tool (Treatment Needs Assessment – TNA) and is in the planning process (draft outline for proposal complete) to

introduce the Voice-DISC (Diagnostic Interview Schedule for Children). This self-administered, computerized mental health assessment tool will provide information on mental health needs, and will indicate the need for more specific assessment, including live person interview, more specific assessment instruments or a Special Program Assessment Needs (SPAN) review. As indicated, additional assessment tools may be utilized as clinically indicated. The V-DISC will provide a clearer diagnostic picture, which will drive sound, more accurate and comprehensive treatment plans. Long-term plans include developing algorithms (decision-tree matrix or process) and aligning treatment activities with the diagnostic result of the assessments.

Through the Safety and Welfare Remedial Plan, the DJJ is developing a classification system that utilizes the principles of risk, need, responsivity and program integrity. Understanding that no one model will account for all the possible variables in the DJJ population, particularly the mental health needs, override decisions will be made as appropriate and will be monitored by a multi-disciplinary team, as defined in the Safety and Welfare Plan. For youth with mental health issues, the acuity of mental illness shall be the primary factor in placement. The plan is to place youth with like risk and need levels in specific mental health programs. The ITDCS will continue to manage the mental health population through expanding programs, headquarter oversight of the placement process, and by including mental health status as an override component of the new classification system. As outlined in the Safety and Welfare Plan, this process will be further defined in consultation with the Court Expert and other nationally recognized experts,

The introduction of the Special Program Assessment Needs (SPAN - a web-based computer program developed as a screening instrument to identify those youth that are in need of mental health services) process has allowed the ITDCS to better manage the priority placement (waiting list) of youth requiring the services of a specific level of care. With the introduction of the V-DISC assessment process, the mental health population will be more clearly defined and identified. The SPAN program also provides data to document the length of time a youth awaits placement into a treatment program.

Full implementation of HCS administration's plan to operate the acute and intermediate care programs (CTC and ICF) will be sufficient for the population requiring those services. This population is also being reviewed for appropriateness of commitment to the DJJ as a component of the Safety and Welfare Plan. Health Care Services is currently in the process of licensing and activating the CTC level of care in southern California, and is reviewing the need for such beds in other regions where facilities currently exist (or may be planned) versus contracting out for these services. The implementation of the CTC level of care within the Mental Health Remedial Plan will be consistent with terms agreed upon in the *Wilber v. Warner* litigation.

Contracts with private community hospitals and county facilities to provide this level of services to all youth, male and female, over and under 18 years of age are in various stages of development and approval. Interim procedures have been identified and distributed to all mental health staff to address the current needs of this population, requiring transport to emergency rooms for assessment of psychiatric needs in the event no contract services are available.

The adequacy of service delivery through utilizing a combination of contracts with private community and county hospitals, Department of Mental Health, the Intermediate Care Facility, and (when licensed) the CTC will be continually assessed. HCS and DJJ administration will meet with the Mental Health Experts and discuss whether the decision not to build an additional CTC should be reconsidered. Placement of youth into beds at state hospitals, under the Department of Mental Health, will be reviewed by HCS administrative staff and subject to utilization management review on a monthly basis to ensure adequate services are provided. These reviews will be available for review by the Mental Health Expert. Again, when all levels of care are available to all youth, and appropriate and consistent intervention can occur at an earlier point in the development of the crisis, programs as they are outlined are believed sufficient to manage the needs of all youth.

Treatment service standards are being developed and will be contained within the specific level of care program guide. These standards will be clearly defined to allow for auditing by the Mental Health Expert. At this time all levels of care are available, but to varying degrees. With the addition of a Correctional Treatment Center (the southern California CTC is currently in the licensure process) the ITDCS will have acute care services available within the existing facilities. The HCS is developing procedures and resources to provide acute care services through contracts with community mental health agencies if necessary.

Based on several studies completed on the DJJ population (Steiner, Humphreys and Redlich), 85% of youth in the DJJ are identified as having substance abuse issues. The treatment programs identified for this population are generally identified as formal (residential) or informal (outpatient). Currently, placement is managed at headquarters, utilizing priority placement lists based upon the youth's Severity Score from the Drug Experience Questionnaire (DEQ). The Safety and Welfare Plan addresses the plan for future development of additional substance abuse treatment services. .

When youth requiring substance or alcohol abuse treatment have been identified as having a co-occurring disorder (mental illness) either through the initial assessment or the SPAN process, placement in the appropriate level of care will occur and treatment will be provided. This may result in a youth being placed on a mental health treatment program, with substance or alcohol abuse treatment being provided within the context of this program and with consideration for the impact the mental illness and substance abuse have on the youth's treatment success.

A youth with mental health issues may also be able to participate in substance abuse treatment as the primary placement, with supportive mental health services provided on an outpatient basis. Guidelines for treatment services for youth with co-occurring disorders will be developed in consultation with the Mental Health Expert and as a component of the treatment activities developed to align with assessments and specific diagnoses. These treatment activities will be a focus of training for all staff assigned to work on mental health programs.

The ITDCS is committed to providing access to care, quality of care and continuity of care with regard to mental health services. The nature of mental illness within the child, adolescent and young adult population is that needs change, mental illness develops and exacerbates for numerous reasons, and that services need to be provided in a timely manner. Resources need to

be available when emergent risks arise and once mental health needs are identified. Thorough screening and assessment, timely identification of treatment issues, intervention at key points in the youth's incarceration, delivery of services in the least restrictive environment, and transitional planning are essential components of treatment programs.

To this end, HCS recognizes the need for expanding current mental health treatment services while also reducing the census on residential mental health programs, for increasing the presence of mental health professionals in all levels of care, for establishing and hiring appropriate staff with specific expertise, for supporting these staff with clerical and technical positions, and for providing mental health leadership at the local level. The implementation of the proposed changes identified in this plan will require adequate staffing, expertise, support, and commitment to change. Collaborative efforts with the Department of Personnel Administration have begun to address concerns with identifying qualified and appropriate staff classifications for newly proposed duties and positions. At this time, short-term goals for mental health services include:

- Reduction of the current population in all mental health programs;
- Enhancing direct service provision to youth on mental health programs;
- Move towards increasing staff to youth ratios, both clinical and custodial/support staff;
- Developing and hiring new mental health classification staff for programs (psychiatric technicians, Senior Psychologist Specialists, rehabilitation therapists, etc.);
- Optimizing the utilization of current physical plants by identifying the most appropriate living unit style for the various mental health population groups (predominantly single, closed rooms);
- Identifying the need for new, additional mental health programs needed to both meet the needs of the existing population and to treat youth as close to home as is possible;
- Involving family/guardians in the assessment, treatment and transition planning processes, and
- Completing the development of a new and thorough mental health assessment protocol that will identify the prevalence of mental illness in youth, identify evidence-based treatment activities and modalities for these youth based on the new assessment process, and define treatment standards for these youth in the program guides for each level of care.

LICENSURE, SUPERVISION AND DISCIPLINE OF CLINICANS

The Health Care Services Delivery System (HCSDS) relies on a variety of mental health and custodial staff to provide a continuum of care to youth. The Medical Director provides leadership, supervision and oversight to all health care programs, including mental health services. The Division of Juvenile Justice (DJJ) continues to assess the organizational needs for the delivery of mental health services.

The Chief Psychiatrist and Chief Psychologist (or similar positions) will be responsible for the supervision, training and discipline of clinical staff providing mental health services to youth (psychiatrists, psychologists, clinical social workers, psychiatric technicians, etc.). The policies

and procedures developed for the HCSDS will provide more information in the area of clinical and administrative leadership, training and quality management.

Health Care Services leadership understands the importance of hiring credentialed, well-trained staff. Professional licensure in several classifications requires a specific number of Continuing Education Units (CEU) or Continuing Medical Education (CME) within a stated timeframe and which are outlined in a CEU/CME policy. Active licensing status is continuously monitored and required as a condition of employment in many classifications. Health Care Services supplements CEU and CME courses by assessing the training needs of medical and mental health staff at orientation, time of release of new policy and procedure, required annual refresher sources, etc. In addition, HCS has identified unlicensed staff within the division, and will develop additional training, supervision and standards for services delivered by these staff. Video conferencing could be used to provide system-wide education to mental health staff.

Specialized training and certification, particularly among psychiatric staff, is preferred due to the population served. Recruitment and retention benefits for psychiatrists and psychologists have been obtained, and hiring efforts for these positions focus on candidates who possess the most appropriate license, credentials and training background. Recruitment efforts have been published in the Psychiatric Times, on the American Psychological Association website, in national periodicals and "word of mouth" inquiries have been directed towards contract service staff. The HCS Medical Remedial Plan identifies in more detail collaborative efforts between HCS administration and universities and research institutes in recruiting psychiatric staff.

Senior Psychologists perform the supervisory role for Staff Psychologists and Clinical Psychologists in the facilities. Typically, a Senior Psychologist is assigned when a new facility opens to complement Staff Psychologists and Clinical Psychologists, and when a new treatment programs opens. They provide the clinical oversight, as well as disciplinary role, for these psychologists.

The proposed position of Chief Psychologist is identified as being the direct supervisor for the Senior Psychologists. This will allow the Chief Psychologist to direct, consult, supervise and audit the mental health services provided within the facility. Supervision and training of psychologists is seen as essential to address quality assurance issues, skill development and disciplinary issues. The HCS administration has plans to re-institute the Mental Health Advisory Committee, a proactive venue for mental health professionals to discuss pertinent issues related to mental health practice, policy, procedures, etc. The position will also be responsible to develop a quality assurance program for psychologists; providing chart and peer review, policy review, teleconferencing opportunities, etc.

Effective oversight and supervision are required to ensure youth receive quality care. Through centralized leadership, local governing bodies and a Quality Assurance and Peer Review Program, mental health services will be coordinated and delivered in a timely, thorough and consistent basis. Standardized job descriptions and duties statement, and the implementation of treatment plan driven services are important components for monitoring staff activities, identifying treatment needs and, when warranted the basis for disciplinary actions. Bargaining Unit contracts define the disciplinary process for staff, the oversight and supervision of staff duties will be the basis for any necessary discipline.

TRAINING

The HCS administration will conduct training needs assessment in the context of staff development and in response to results of management audits, peer reviews, surveys, and reviews of general medical and mental health conditions within the youth population. Policy to address licensed medical and mental health staff's completion of CME and CEU courses appropriate for services to youth population exist and will be monitored and documented. A training program will be planned, developed, coordinated and implemented, focusing initially on new and current policies and procedures. All training courses are evaluated and records of attendance are maintained.

The HCS administration continues to work actively to develop training for psychiatric and other clinical staff, joint research projects, and fellowship programs with Stanford University, University California Davis Mind Institute and other institutes for higher learning. Efforts to develop video-conferencing, as well as telemedicine opportunities with experts in child and adolescent psychiatry from these institutions will also be considered. The HCS Medical Remedial Plan provides more detail in the area of training for psychiatrists and psychologists.

In addition to existing training programs, HCS will develop a staff development and training program to ensure on-going staff development efforts, training, peer review, etc. This program is planned to include a Senior Psychologist Specialist in the HCS administration and several located in each facility. Training efforts related to mental health will be coordinated through these positions, and could also include the development of an APA-approved psychology intern program, to provide opportunities for recruitment. Initial efforts in this endeavor will be focused primarily on developing the sites and feeder schools, preparing training manuals, training staff, development of forms and associated procedures, and establishing psychology intern positions. Considering timeframes for the development phase of this program, this is seen as an immediate goal for HCS.

The Integrated Treatment Delivery of Care System (ITDCS) is moving towards developing services built on evidence-based screening, assessment, and treatment modalities. These services, to be effective and transferable upon release to parole, need to be supported by all staff that has contact with youth in the DJJ. Reinforcement, common-language and consistency are essential if youth are to enhance essential skills prior to reintegrating into the community. Considering the census of youth in the DJJ who have been identified with mental health diagnoses and needs, training all staff in the tenets of strength-based, cognitive behavioral techniques will be required. Additionally, training for emergent risk issues (suicide risk, signs of possible mental illness and substance abuse, etc.) needs to be done division-wide, from the local administration level down.

Training needs on several levels, and at specific timeframes, have been identified by HCS administration staff. DJJ has contracted with California State University, Chico (CSUC) to complete a training needs assessment, wherein existing training will be reviewed, assessed and modified as needed, and a training need assessment report will be completed. The training needs identified by HCS staff will supplement (in many areas) the training needs currently meet by the DJJ's existing training program. As new components of the mental health delivery system are

implemented (policies, procedures, assessment protocols, individual treatment planning, interactive journals, treatment activities and new modalities, etc.), all staff involved in these changes will receive training. In addition, program guides will identify changes in the structure of mental health programs to include "on-the-job" training opportunities for staff on mental health treatment programs, including co-facilitation of groups, participation in case conferences with professional staff, consultations and clinical staffings with mental health professional staff, etc.

Preliminary training needs and schedules would involve:

- Basic mental health training for all new DJJ staff during the Orientation Training;
- A comprehensive mental health module for all peace officer staff (YCO, YCC and CWS) entering the Basic Academy;
- A comprehensive mental health module for all staff assigned to work on mental health programs or in out-patient mental health services;
- On-going specialized training for mental health professionals on topics related to the specific population served;
- Annual block, refresher training on new/revised policy, procedures, emergent issues or modalities;
- Quarterly team building/meetings for staff assigned to work on mental health programs or in out-patient mental health services;
- Participation in courses required for maintaining professional licensure.

Recent program changes implemented in7/04 utilize Cognitive Behavioral Therapy (CBT) as one of the primary treatment modalities. All staff involved in providing direct services to youth will be trained in this modality to ensure an integrated approach. Identified Treatment Issues, treatment notes will be documented in the treatment plan/ICAP, all relevant files and in the Ward Information Network (WIN), as appropriate. The Interdisciplinary Treatment Team (IDTT) will ensure that the focus of all treatment be based in the tenets of Cognitive Behavioral Therapy. To ensure transition of these skills, the field parole staff that manages the parolees with mental health issues (including sex behavior and substance abuse treatment issues) will continue to be involved in transition-related trainings provided to institutional mental health staff. This will improve the quality of services provided, improve transition planning, allow for a truer continuum of care and for the transition of skills learned in the facility to the community.

2. Standardization of Mental Health Care Delivery

ADEQUACY OF POLICIES AND PROCEDURES

The Integrated Treatment Delivery of Care System (ITDCS), through the development of standardized policies and overseen procedures statewide, will guide treatment service delivery and provide quality care. Existing policies and procedures are currently being reviewed and updated by identified administrative staff and standing committees (to be continued on an annual basis), taking into consideration new and amended statutes, regulatory changes, administrative

mandates and recommendations resulting from standing committees and identified work groups. Policies and procedures are subject to review on an as needed or annual basis.

Health Care Services (HCS) identifies the office of the Medical Director as managing the documentation of policy development and implementation. Documentation of implementation activities shall include: a master set of HCS policies and procedures with the most recent revision dates or the development date clearly indicated and signed by the appropriate management staff, evidence of Medical Director review and approval and date of approval (if applicable), corresponding local procedures at each facility to define specifically how the HCS policy and procedure will be implemented and evidence of local approval from HCS.

The ITDCS specifically targets the policies and procedures of mental health care delivery system, under the umbrella of HCS. The operation of the ITDCS is not to be directed solely by mental health-related policy and procedures, but to work in conjunction with the existing policies and procedures established by the Facilities, Parole Services and HCS as they relate to providing services to youth. It represents the process for delivery of mental health services department-wide. Starting at the acceptance of cases, through intake, screening and assessment, identification and placement in the appropriate level of care, service delivery and culminating at transition to parole supervision, the ITDCS defines policies and overseen procedures that are currently in practice in mental health services.

Consistency and integrated treatment are the goals HCS has set for the delivery of mental health services. A partial list of the components of the ITDCS where standards are being developed and integrated into policy and overseen procedure are identified below. Stages of development are identified behind each policy (i.e. C = Complete with final approval; P = Complete but pending formal approval; D = Draft ready for review; I = Need identified and in development progress).

- Integrated screening and assessments (I);
- Process for identification of mental health issues in youth (D);
- Initial risk assessments (I);
- Psychiatric and psychological evaluations (D);
- Integrated and evidence-based mental health treatment services (Cognitive Behavioral Therapy, Motivational Interviewing and Enhancement Skills, Dialectical Behavior Therapy, etc.)(I);
- Individualized treatment planning (D);
- Mental health referral process (P);
- Mental health level of care system (D);
- Mental Health Program Guides (D);
- Standards for family involvement in assessment, treatment and transition (D);
- Suicide Prevention Assessment and Response Policy (P);
- Seclusion and Restraint Policy (I);
- Discharge, aftercare and transition planning (D);
- Guidelines for documentation, report writing, etc. (I)
- Mental health concerns in use of force, Disciplinary Decision Making System (DDMS), grievances, etc. (D)

Policies, procedures, program guides, etc. are currently under review and development. With the hiring of the Chief Psychiatrist and Psychologist, the staff in positions of leadership will be available to more closely direct and organize the policy development of the ITDCS.

The provisions of the Health Care Services Medical Remedial Plan concerning policies and procedures include policies and procedures for mental health care except as modified in this plan. The Chief Psychiatrist will review all Health Care Services policies and procedures that are required to be developed and ensure that they appropriately address mental as well as physical health issues. The mental health portions of policies and procedures required by the Medical Remedial Plan will be completed on the timetable set in that plan. The following policies are currently in draft and pending review:

- Use of Mechanical Restraint;
- Emergency Psychotropic Medication;
- Abnormal Involuntary Movement Scale;
- Anti-psychotic and mood stabilizers-laboratory monitoring;
- Psychotropic PRN;
- Lab Monitoring of Psychotropic Medication;
- Polypharmacy;
- Informed Consent for Psychotropic Medications, and
- Psychiatric Referrals and Crisis Response.

ADEQUACY OF MENTAL HEALTH RECORDS

The Health Care Services (HCS) clearly defines the organization of the Unified Health Record (UHR). The health record system is intended to address all areas of health record information management. Standardized policies and practices address the flow of patient health information, including mental health services, and is accomplished utilizing trained staff (Health Record Service Personnel). The Health Record Service staff has four major responsibilities: file maintenance, release of confidential information, technical record processing and quality control.

Health Care Services has revised the organization of the UHR, as well as policies and procedures regarding access to the health record and the release of confidential medical information. Activities and functions are coordinated so that the UHR is available to members of the Interdisciplinary Treatment Team (IDTT) staff who are authorized access. Requests for the use and disclosure of confidential information shall be processed in compliance with statutory and regulatory mandates and HCS policies and procedures, with information being available to employees on a need-to-know basis. Training will be conducted to implement new forms and revised policies and procedures. The Clinical Health Record Administrator and other staff conduct facility site visits annually to ensure compliance as a quality management function.

Centralized oversight, an integrated treatment approach and the quality assurance process will provide the organizational structure and policies and procedures to ensure that accurate, well organized and complete information is available to medical staff. Currently, Health Care

Services is revising several policies and procedures that address organizational, format and medical practice concerns related to mental health staff. The Integrated Treatment Delivery of Care System (ITDCS) will rely on standardized policy, local (but overseen) procedures and clearly defined roles of all mental health staff to operate effectively.

Currently, the Individual Change Plan (ICP) is utilized as the integrated treatment plan, and is reviewed at intervals of every 30 to 120 days, for each youth within the DJJ. Identified Treatment Issues (ITI) are identified by mental health, education/vocation and custodial staff, and are documented on the youth's ICP. Each ITI includes the identified treatment issues, goal, resources to address the ITI, staff to provide the resource, frequency and duration of resource, start and completion date and progress summary. All areas of a youth's treatment are addressed in the integrated ICP, documented in the Ward Information Network (WIN) system, and available for all authorized staff to review.

The ITDCS will plan to develop procedures to ensure the relevant information in the ICP is filed in the UHR for review by medical staff. Although many staff working in a variety of positions in each facility have access to the WIN system, immediate and consistent access is essential to ensure quality care. A prototype for a new mental health treatment plan, specific to the services provided by mental health professionals, is currently in development.

Treatment issues and target behaviors will be identified, specific goals set, and the appropriate evidence-based treatment modalities and interventions will be identified in collaboration and with input from with the youth, family and Interdisciplinary Treatment Team (IDTT). Services identified will be documented in the treatment plan/ICAP and the WIN system, as appropriate, and specific confidential mental health treatment documentation will be placed into the UHR. This will allow for the separation of information considered confidential and subject to the Health Insurance Portability and Accountability Act (HIPAA) compliance, and will also ensure that the most current service delivery information is available for review by mental health staff reviewing the UHR.

Recent updates have been made to the WIN system, improving the standardization and documentation of mental health services. Each youth has an electronic "ward record", which includes a "tab" identified for mental health services. New mental health "screens", which provide expanded information and formats for documentation of direct service have been implemented statewide. A standard "SOAP" note (mental health treatment record) format will be utilized when documenting individual therapy/contacts with youth. The "SOAP" note is then printed and filed in the UHR. The recently modified mental health screens have been implemented, and automation of mental health records is an on-going goal for the ITDCS.

In efforts to ensure quality and continuity of care, and to foster integrated treatment delivery, the policies and procedures for writing medical orders have been clarified and will be continually reinforced through quality assurance audits and peer review. The practice of writing orders on progress notes will be ceased and physicians (psychiatrists) and psychologists shall write all medical orders on a Physician's Order Form (POF). The management of medication shall continue to comply with State and Federal Laws and regulations, follow the policies and procedures identified by HCS, and are included in the Quality Management System. The existing CIPS Pharmacy System automates this service, but further automation of medical and

mental health services is also in development. Health Care Services administration continues to further development and implementation of automated pharmacy programs in an effort manage medication costs, project budgets, collect data for quality assurance and for cost efficiency and standardization.

PRESCRIBING PRACTICES AND DOCUMENTATION OF PSYCHOTROPIC MEDICATION

Health Care Services (HCS) shall provide accurate and timely management of medication of youth. Medication management (including ensuring the medication is delivered) is a responsibility shared by custody and correctional healthcare staff. Health Care Services is developing policies and procedures in the areas of the pharmacy services and medication management.

The DJJ has a significant number of youth taking psychotropic medications, many of which can cause heat sensitivity during hot weather. The existing organized heat plan has been revised and is more clearly defined in the HCSDS. Identification of a youth at risk is a key component, in assuring that procedures to remediate any potential side-affects are effective. Training in the side-affects of medication and cooperation between clinical, custodial and pharmacy staff is essential for the plan to be effective. Management of medication utilized during these periods will be addressed in training and medication management reviews.

Documentation of medication practices is addressed in detail in the "Pharmacy Services/Medication Administration Policies and Procedures" section of the HCS Medical Remediation Plan. Some significant areas identified which relate to mental health programs include: administration, monitoring and tracking of medication, local operating procedures for medication management, cross-referencing Physician's Orders with the Medication Administration Record (MAR), formulary issues, requirement information in a medical order, timeframes for seeing youth on medication upon transfer, PRN orders, "HS" and "Stat" medications, licensing issues and requirements, Keyhea (involuntary medication), and identifying youth prior to medication administration.

The guidelines for accurate and timely management of medications are clearly defined according to community standards. Auditing and quality assurance procedures are being developed to ensure compliance. Health Care Services policy and procedures identify several quality assurance and control committees that are charged with directing, monitoring and disciplining service providers, as well as the system itself.

Policy and procedural guidelines only partially address the issues. Clinical assessment, diagnostic assessment skills and expanding the knowledge base of psychiatry staff in modern pharmacology are areas of concern for which HCS is developing training, tele-medicine and peer review processes. Immediate communication from the HCS administration regarding the medications available in the formulary, including stimulants and the need to utilize them when indicated, has been disseminated. Identifying areas of strengths and difficulties in clinicians can provide invaluable information for training and improvement of professional practice. Peer

review and chart audits can identify areas of risk that require further inquiry and possible remediation.

Health Care Services is addressing the issue of psychotropic medication management through membership on statewide committees and in collaborative efforts with the California Department of Corrections Rehabilitation (CDCR) Adult Services medical staff. A seat for membership on the Psychopharmacology Advisory Committee, a statewide committee that is developing and researching algorithms appropriate for the juvenile corrections setting, is assigned to HCS and psychiatrists are assigned to fill these by the Chief Psychiatrist. The ITDCS will be under the umbrella of the resulting recommendations and will utilize the results of the committee's efforts.

Through collaborative efforts with CDCR Adult Services medical staff, HCS is also considering implementation of the VISTA system, an electronic medication ordering system and mental health progress note to ensure the appropriateness of prescriptions based on algorithms. This would allow Health Care Services administration to monitor for inappropriate poly-pharmacy and best practices. The use of algorithms as comprehensive guidelines will allow the ITDCS to implement evidence-based treatment that will result in consistent patient care that is economic in the long-term and allows for the development of outcome measures, which allow objective assessment of patient progress.

Health Care Services recognizes the need to treat the "whole" youth, and training should include all staff that provides services. Correctional medicine involves custodial and education/vocational staff, documenting their observations and knowledge of youth's behavior that provides essential diagnostic information. The Interdisciplinary Treatment Team (IDTT) shares the responsibility for treating the youth. Involving more staff means more "eyes" are identifying the change in a youth's mental health symptoms, the side effects of medications, progress towards treatment goals, etc., which will enhance the treatment process.

The training packet for mental health issues will be given to all staff that observes a youth in the course of a day. Enhancing the staffing on mental health treatment programs by introducing Psychiatric Technicians into the staffing pattern will provide a resource to mental health programs with credentialed/licensed skills in the area of medication management and symptom education that will be valuable to custodial and lay staff.

3. Access to Care and Quality Assurance

PROVISION OF MENTAL HEALTH CARE

The Division of Juvenile Justice (DJJ) will provide comprehensive mental health services to all youth in need on a continuum of care basis. Strategic planning for mental health services to youth is in progress with the vision of providing a comprehensive, full continuum of care that is tailored to the youth's needs, including both psychotherapy and pharmacological therapy. Individual Change and Accountability Plans will be developed to match the youth's specific treatment needs. The Integrated Treatment Delivery of Care System (ITDCS) will provide access to a full spectrum of treatment programs, services and resources within it's facilities, in other departments (e.g. Department of Mental Health, Department of Developmental Services)

and in the community (e.g. outpatient services, conservatorship, hospitals), in order to meet the treatment needs of all psychiatrically disturbed youth.

The ITDCS has moved toward standardizing treatment services for all youth by identifying Cognitive Behavioral Therapy as the basis for service delivery, understanding that other theoretical models may be better suited for specific treatment issues. The new Core Program is the primary tool for laying the basis of the treatment model, and will be implemented on core as well as mental health programs. It is based on three concepts, all of which are research and evidence-based: the Trans-theoretical Model of Change, Cognitive Behavioral Therapy and Motivational Interviewing. Currently, the primary vehicle for delivering this model is a series of Interactive Journals, customized for the DJJ by The Change Companies. These journals are designed for independent use by youth, but will also be presented in a small group format by the Case Manager and treatment staff. The underlying treatment concepts will be reinforced in all areas of a youth's treatment, as well as being the primary treatment concepts driving staff interventions with youth.

The program is supported by a "check system", which involves real time interventions staff can utilize to build a youth's strength and also supports the tenets of the treatment program. The ITDCS will also develop more intensive needs journals, beginning immediately, to address specific treatment issues at a more in-depth and long-term level. On-going support has been provided by the contractors, in the form of training, video support, and implementation consultation. Initial planning for developing target behaviors for change, and identifying objective outcome measures (desired behaviors) has been initiated. The Interactive Journal programs (Core and Intensive Needs) will be an essential component of a youth's treatment, focused specifically on the change process, developing strengths and transferable skills for reentry into the community and utilizing a language and philosophy that both staff and youth support.

Recognition of what interventions are successful in changing a youth's behavior and thinking is an essential component of an effective therapeutic milieu. Additionally, recognizing that a youth's strengths and abilities should be a factor in deciding the type of intervention and sanction for negative behaviors is also essential. To this end, based on consultation with the Mental Health Expert, extensions (time adds) to a Parole Board Date (PBD) for youth identified with mental illnesses will not be an option as a disposition for a negative behavior report (within the Disciplinary Decision Making System - DDMS). Dispositions will be identified in consultation with the youth's assigned mental health clinician and aligned with identified treatment issues as documented in a youth's treatment plan/ICAP. Extensions to a youth's PBD will be based on the youth's readiness to transition back to the community.

The DJJ is also in the beginning stages of developing a comprehensive training program for all staff that deliver mental health and rehabilitative services to youth. In addition to training on policy and procedure, additional training in support of the new core program outlined in the Safety and Welfare Plan is also being researched and identified. The ITDCS is developing a training program that includes more intensive training in Cognitive Behavioral Therapy, as well as Dialectic Behavior Therapy (DBT). Mental health staff from the Ventura YCF has received extensive training in DBT and they most likely will be called upon to assist in identifying and

developing a training packet for staff. Also, outside agencies and contractors will be approached to develop more specific training in this area.

The Change Companies, who collaborated with the DJJ and developed the Interactive Journals now being used, have also expressed an interest in providing more intensive training and in developing research in the area of target behaviors and outcome measures with regard to the youth's progress in changing their behaviors, developing coping skills and in their utilization of these skills in their daily lives. An existing contract with the Change Companies may be amended to address this need, or new contracts will be developed.

Staff will be utilizing the new risk/needs assessment, described in the Safety and Welfare plan, and other assessments, as needed, to assist in identifying treatment issues. The Core Program components will provide resources for addressing the assigned goals which will be documented in the Individual Change and Accountability Plan (i.e. treatment plan). The Ward Information Network (WIN) will be modified, as needed,to identify the journals as "pull down" options for required resources to address treatment goals. They are structured, close-ended and time-limited journals. This process currently begins at the Reception Centers and Clinics, utilizing two, specific journals to introduce all youth to the program, it's concepts and the DJJ. The Initial Case Review identifies treatment goals, and where applicable, the related core journal to address it.

Plans for training all mental health professionals, at a more intensive, clinically advanced level, on the core components of the program will be developed. The possibility of identifying programs utilizing this model and requesting assistance in the form of program review and consultation/training is in the beginning stages. Additionally, the education department is developing a process to include the journals in services they provide. This will ensure all members of the Interdisciplinary Treatment Team (IDTT) are using the same concepts and language in their contacts with youth, and that treatment is truly integrated.

Overall treatment planning in general has been addressed in more detail within the ITDCS. Currently, beginning at the reception centers, screenings, assessments and referrals identify the targets of future treatment, types of programs, interventions and level of care for all youth. The initial assessment process will be enhanced to identify mental health diagnosis, cognitive delays and suggested treatment interventions. The enhanced cognitive screenings, completed in collaboration with education services, will identify youth that may require accommodations that will be addressed within the Ward's with Disabilities Program.

Contact with family and guardians by members of the treatment team, will be conducted at arrival to gain insight into the youth's psychiatric, familial and behavioral history. Efforts to identify existing interview formats for familial contacts are in progress, and will be incorporated into the assessment protocol process to ensure access to information is obtained from family and guardians. This may include the family interview format of the V-DISC. The new risk/needs assessment, described in the Safety and Welfare plan will have a family domain. Collaborative efforts with other state agencies, or with existing DJJ staff with specific expertise, in identifying and overcoming cultural barriers to communicating and understanding the cultural backgrounds of families will be developed to engage family members early on in the youth's commitment. DJJ will initiate programming and services focused on involving families and guardians in

sharing information regarding on-going and transition services for their children will also be researched and developed. The Mental Health Expert shall ensure, through auditing, that these practices are enforced. The procedures for implementing such programming and services will be provided to the expert in draft form by March 1, 2006, with an implementation schedule to phase in these services. Small scale, pilot programs will be considered for youth on mental health programs, with wider-scale development being a long-term goal.

Treatment planning continues to be integrated throughout the youth's program. To ensure continuity of care, the Interdisciplinary Treatment Team (IDTT) will be clearly defined in the policy and program guides of the ITDCS, including all classifications from custody staff to mental health professionals. The guidelines and responsibilities of the IDTT will also be defined in relation to mental health treatment planning at all stages of a youth's program, services provided by each classification, documentation procedures, supervision, and the continual assessment of mental health needs and level of care. Specific issues and required interventions present at critical stages of a youth's treatment (intake, progress conferences, crisis, change in level of care, transition and/or parole) will be clearly defined with expectations that must be met by all IDTT members.

The ITDCS continues to address identified "gaps" in service delivery through the implementation of action steps previously identified by HCS administration. The ITDCS program guides will identify the three separate but integrated levels of care, each of which have clearly defined expectations and standards for the mental health services to be provided. All members of the IDTT have standards of care to follow, which when considered collectively, will provide sufficiently for the treatment needs of the youth. On-going program assessment involves standardizing and defining service needs, policies and procedures to better assess what can be provided within existing resources, and what additional resources may be required to provide adequate services to youth.

As discussed throughout, certain issues raised in the Expert's report, e.g. the Disciplinary Decision Making System (DDMS) and grievance procedures are discussed in the Safety and Welfare Plan. Mental health presence in these processes for youth with mental health issues allows for informed due process, accommodations as needed, the development of appropriate interventions and a more integrated approach in treating the youth as a whole.

STAFFING

The ITDCS provides mental health treatment utilizing a community care model and a level of care system. Policies and procedures are being standardized statewide, and one basic and consistent treatment modality has been identified across the mental health system (Cognitive Behavioral Therapy, with Dialectical Behavior Therapy in specific circumstances). Program development efforts will focus on hiring licensed and certified mental health professionals, bringing in new classifications, and establishing treatment guidelines for ITDCS staff assigned to each specific mental health program (mental health professionals, custody and educational staff).

Several new procedures have been initiated in the DJJ where a licensed clinical staff must be involved in a review process Statutes 2003, c. 4, SB 459 calls for mental health staff participation in Youth Authority Board and Administrative Committee hearings) by attending hearings both at DJJ and CDCR (adult) facilities. This process will be shared between Senior Psychologists and Senior Psychologist Specialists. All are part of the Interdisciplinary Treatment Team for their respective work sites, both in special treatment programs and the core program living units of youth receiving their clinical services. This newly developed duty has had a significant impact on the provision of direct services, and will have to be addressed to ensure no lapse in services occurs.

Staffing deficiencies have been identified by the expert's as limiting service delivery across the spectrum of mental health programs. Recruitment and retention efforts in hiring psychiatrists and psychologists have been on going. Health Care Services continues to identify strategies to fill vacant psychiatric positions and to develop a candidate pool for future positions. Efforts towards developing joint research projects and fellowship programs with universities and research institutes continue, as do advertising in professional periodicals and websites. As stated previously, plans to develop cooperative efforts with the Universities of California at Los Angeles and San Diego to develop quality assurance and peer review programs in addition to consultation are being researched as avenues for recruitment efforts.

Psychologist positions have also been a focus for HCS, and the Psychology Associate and Intern positions have been utilized and have lead to hires as well as enhanced psychological services. Health Care Services has negotiated and implemented an on-call program with psychologists, ensuring psychological services are available to youth on suicide watch on weekends and holidays. As with psychiatric staff, recruitment and retention issues continue to be addressed in an ongoing effort to support the DJJ's efforts to fill vacant positions (e.g. psychologists, licensed psychiatric technicians, registered and/or psychiatric nurses, etc.), and to ensure that funded mental health positions are sufficient to deliver prescribed treatment services. CDCR will inform DPA of the need for pay parity within the department, and the consequences of inaction, for health care practitioners.

On all treatment and core program units, the Youth Correctional Counselor (YCC) is a member of Interdisciplinary Treatment Team (ITDD) and provides rehabilitative/treatment services in addition to performing custodial duties. Across the mental health programs staffing varies, and additional duties are being required of the YCC class. Balancing custody needs and providing time to perform counseling duties is a concern the DJJ is working to address from different perspectives, including introducing psychiatric technicians onto mental health programs. Psychiatric technicians are not responsible for operational or custody duties, their primary responsibility is to provide direct mental health services to youth. They are also licensed and trained to provide both medication administration and crisis intervention, often needed on mental health programs.

As identified previously, an increase in staffing numbers will not in and of itself resolve concerns with the quality and delivery of services. Mental health staff will provide services as a member of an IDTT, communicating with and supporting other members, and fulfilling the identified expectations for service delivery. Each member of the IDTT plays a vital role in the

rehabilitation of the youth in their care, and although each brings a particular expertise and role to the team, it is essential that all efforts are coordinated, complimentary and driven by the mental health needs of the youth.

Staffing levels, necessary to deliver mental health care services, shall be established by the directives of policies and procedures, and treatment guidelines. Staffing levels will be subject to both internal and Court expert monitoring. Under the guidance and supervision of the DJJ Medical Director, Chief Psychiatrist and Chief Psychologist, annual monitoring will be a part of developing the budget process at each facility.

Newly hired psychiatrists must be Board Certified or Board Eligible. Psychiatrists without appropriate credentials or privileges shall not be permitted to work. The Chief Psychiatrist shall review psychiatrist scheduling practices and productivity, and shall monitor each psychiatrist's compliance with policies and promulgated clinical guidelines. Psychiatrists shall be required to document each medical contact and encounter in the youth's Unified Health Record.

Mental health clinician staffing was determined by an initial assessment performed by the Transition Team. The adequacy of this staffing arrangement will be subject to internal audits, and external audits by Court Experts on an ongoing basis. The assessments will take into consideration the number of youth at a facility, the mission of the facility and the mental health services provided. Additionally, consideration will be given to the availability of mid-level practitioners (nurse practitioners or physician assistants). These clinicians may be included in the staffing pattern for physicians. When utilized, nurse practitioners or physician assistants report to a supervising physician. Psychiatrists will be required to undergo credentialing and privileging as a requirement of employment.

Psychiatrist peer review shall be performed at least quarterly at each facility. The Medical Director and Chief Psychiatrist will develop audit tools and reports of the findings of the peer reviews that will:

- Identify deficiencies;
- Make recommendations for improvement generally as in making improvements in the system of care and specifically for each practitioner by giving feed back to the clinician;
- Focus on high risk, problem prone aspects of patient care, and
- Provide direction for specific quality management activities.

SUFFICIENCY OF ANCILLARY STAFFING

The Division of Juvenile Justice (DJJ) is committed to providing adequate treatment services to its youth in the safest environment possible. DJJ understands the cooperative and collaborative efforts that are required amongst all staff in the facilities, and the supportive function of staff in Headquarters, to ensure that DJJ's vision and mission are fulfilled. Adequate staffing with appropriate and trained support staff will be required to provide the standards for treatment

services being developed. It is essential not only for the mental health programs, but in core program services as well.

Custody staff (Youth Correctional Counselors and Officers) is required to ensure service delivery and safety within the facilities, and can play an essential role in maintaining a therapeutic and supportive environment where treatment occurs. Nursing staff and the planned introduction of psychiatric technicians, will be a critical component of the Interdisciplinary Treatment Team (IDTT) on mental health programs. Psychiatric technicians are licensed, bring a skill set specific for working with mentally ill youth, and can provide both supportive services for medical concerns (medication management and administration) as well as crisis and treatment intervention to the team. These skills can be utilized for direct services, as well as in-service and on-the-job training for counselors. The DJJ continues in its recruitment and retention efforts for these professionals. To ensure an integrated system of service delivery, nursing staff will provide essential professional services on the residential programs to the mental health youth in the DJJ.

Medication management, through pharmacy, also represents a crucial component of the ITDCS and the Health Care Services Delivery System (HCSDS). The HCSDS policies and procedures provide details of the importance of Pharmacy Services with regard to regulatory and organizational issues, but also essential is the consultation role the pharmacy staff will play when working with psychiatric staff in their role of providing essential direct services to mental health youth. The development of systems and procedures for custody staff involvement in the delivery of services and medications that foster cooperation and support in the delivery of service is essential to have on a 24-hour basis. The identification of continuous quality indicators, in the form of standards that directly identify a youth gets the medication needs met as ordered (e.g. at specific times, in a specific form), will be identified and documented as part of the Quality Management program.

CRISIS MANAGEMENT AND SUICIDE WATCH POLICIES AND PROCEDURES

It is the policy of the Division of Juvenile Justice (DJJ) to take all necessary precautions to prevent suicides and suicidal behaviors by youth. The DJJ has implemented a Suicide Prevention Assessment and Response (SPAR) policy statewide, which is a comprehensive program that includes the following components: identification, assessment, referral, prevention, intervention, communication, notification, reporting, housing, monitoring, review and training. The SPAR policy has recently undergone extensive review and revision based on feedback from expert consultants, standing departmental committees, incident reviews and suicide attempts and completions. The draft policy is complete, pending automation updates and then final approval.

Health Care Services is invested in implementing a suicide policy that protects all youth, and solicited Technical Assistance from the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to provide criticism and suggestions for improvement of the SPAR policy. Feedback regarding reduction of isolation, improved documentation, identification of details for staff roles and responsibilities, etc. was incorporated. Site and the Departmental SPAR Committees meet regularly and review local incidents and regional statistics and issues, communicating with mental health administration to address trends, training needs, equipment needs and policy

revision recommendations, etc. The development and utilization of action plans based on the results of suicide reviews for the purpose of audit and risk management are also incorporated into policy revisions.

Physical plant concerns with regard to the installation of "safe rooms", resulted in all facilities having standardized safe rooms developed and operating. Modifications to rooms included: removal of metal beds and installation of concrete slabs, replacement and re-configuration of windows and cameras, installation of combination toilet/sinks, and replacement/reconfiguration of lighting fixtures.

The Post-Suicide Watch Precautionary Plan has been implemented, and a standardized form has been developed for use statewide with the implementation of the most recent revision of the SPAR policy. Revisions to the Operational Analysis procedure will be finalized, focusing on the concept of a "suicide autopsy", with a forensic rather than investigatory focus. Standards as identified by the National Commission on Correctional Health Care will be followed in developing a guide for the psychological reconstruction of youth suicide. Training requirements, ensuring mandatory training for all DJJ staff that interacts with youth, will be clearly defined in the development of training modules.

As a result of an Interim Measure, revisions and development of interim policies and procedures for identification and assessment of suicidal and acute youth have been implementation. Medical staff (psychiatrists, psychologists, licensed social workers) are responsible for identifying youth as being suicidal, based on standardized assessment (file and log review, structured interview, assessment instruments, clinical judgment, etc.), and for the development of a treatment plan that addresses areas such as: need for continued placement in safe room, amount of in-room hours, level of custody staff supervision, need for direct supervision, ability to engage in program activities, need for assessment of level of care, development of the Post-Suicide Watch Precautionary Plan, etc. Partial implementation of the interim measure, i.e. the availability of direct supervision of youth by staff while involved in program activities, services, etc. outside the safe rooms as ordered by mental health professionals, treatment planning and notification to HCS administration is complete. Training was developed and implemented upon final approval of the interim policy. The only component outstanding is the automation of the process in the Ward Information network (WIN).

The new policy provides for direct supervision when a youth is out of the room, which will limit isolation in the safe room, limit time spent in safe rooms and allow youth to interact and reintegrate in programs, activities, services, meals, education, etc. while under supervision. Direct supervision will be ordered by the treating mental health professional, and will be done at a safe distance to ensure the youth's safety but limit possible stigmatization. Continuous review of the implementation of policies and procedures will occur, with oversight at an administrative level to address implementation or policy revision concerns. A review process has been developed to ensure treatment plans are appropriate and the needs of the youth are being adequately addressed.

USE OF MECHANICAL RESTRAINTS ON MENTALLY ILL YOUTH

The DJJ recognizes that policy shall direct staff's actions when considering using controlled force on youth identified as being mentally ill or as having mental health issues. These youth often display resistive, violent and destructive behavior due to symptoms related to their mental illness. The DJJ Use of Force Policy has been revised as a component of the Safety and Welfare Plan, and is discussed in that plan. All facility staff has been trained to adhere to these policies. Additional training for staff, specifically teaching de-escalation skills, will be developed and included in the mental health training modules.

The procedures identified include the following: methods to identify youth with mental health needs, situations where specific interventions will be utilized (immediate versus controlled force); situations involving mental health youth that may require controlled force, steps to be taken by mental health, custody and program staff in controlled force situations (identification, rapport and dialogue, examples of de-escalation and clarifying dialogue, etc.), a progression of staff intervention including the involvement of assigned Youth Correctional Counselors and/or living unit staff, mental health staff, managers and up to and including the Superintendent. In cases where force has been used on a youth in a mental health program, subsequent to that use a crisis intervention plan will be developed by the youth's treatment team (in collaboration with the youth) that will specifically address how to respond to any future crisis. This plan will identify triggers, youth and staff interventions, progression of interventions to de-escalate crisis, timelines for isolation of youth from triggers (time out, counseling off living unit, etc.), and steps that will be followed when interventions do not de-escalate crisis. The policy reinforces the concept that staff need to take any and all precautionary steps to avoid an escalation of force options with mental health youth whenever possible.

Review of incidents of force involving mental health youth, as a component of both policy review and quality assurance, will be ongoing and well documented with the aim of reducing future incidents. The DJJ and each facility convene a Force Review Committee (FRC), which conducts standard reviews of all incidents requiring a use of force. When incidents of force on youth identified as mental health are reviewed, a mental health professional from the facility shall be notified to participate in this review and will assess documentation, video, etc. to ascertain if policy was followed and if the use of force was appropriate. Comments regarding this use of force shall be documented in Force Review Committee reports. Utilizing the Ward Mental Health Master List, the mental health youth of each facility and statewide can be broken out to ensure a specific and detailed review of use of force on mental health youth, and identify policy compliance issues. Trends can be identified, information communicated to treatment staff and interventions tailored to address the underlying issues driving the behavior requiring a use of force.

PROGRAMS AND SERVICES PROVIDED TO YOUTH ON RESTRICTED HOUSING UNITS

The Special Management Program (SMP – to be modified to Behavior Treatment Program (BTP)) within the DJJ is designed to provide a highly structured, short-term, segregated program environment. Youth are identified and referred to address violently disruptive behavior, with the

goal of the future BTP being to return the youth to a less restricted program environment upon completion.

Over the past year, the DJJ has developed policies and procedures addressing placement and services provided to youth with mental health concerns in Special Management Programs. Criteria have been developed that differentiates mentally ill (fragile) youth from youth with lower acuity levels of mental illness (identified on the Ward Mental Health Master List). These criteria (for youth with low acuity) cover issues including: current level of care, need for psychotropic medications, suicide risk status, current signs of psychological distress, recent placement on suicide watch, organic impairment, history of psychological decompensation while in a restricted environment, developmental delays, etc.

Exclusionary criteria were developed, with temporary exceptions for placement to be based on exceptional incidents of violence, safety concerns for staff and youth and the lack of available beds in appropriate programs (in particular the Intensive Behavior Treatment Program – IBTP). To place a youth who met the exclusionary criteria into a SMP, the development of a mental health treatment plan and identification of specific mental health staff to provide a treatment plan driven number of direct service hours and review at the headquarters level were required prior to approving placement of a youth with a mental health issue or illness into a SMP.

Currently, when mental health youth are temporarily placed in an SMP as an exception and not the rule, they receive mental health and medication services commensurate with their identified level of care placement. Services continue immediately upon placement into the SMP. Mental health staff in the Core Program Outpatient Services (CPOS) (psychiatrists, psychologists and Casework Specialists) provides the services identified in the mental health treatment plan and ICP, in conjunction with SMP staff. Nursing staff provides medication services, following Direction Observation Therapy. Any psychological decompensation to the point where acute care is required will result in immediate referral and transfer.

The Safety and Welfare Plan outlines a plan for Behavior Treatment Programs, which will replace the current Special Management Programs and ensure that any youth placed on these programs receives mental health services while undergoing behavior modification services.

INITIAL SCREENINGS

The Integrated Treatment Delivery of Care System provides a coordinated and timely intake screening and assessment process for all youth entering the DJJ. All youth receive medical, dental and mental health screening and assessment within twenty-four hours of intake. The ITDCS utilizes the Treatment Needs Assessment (TNA) process as one means of identifying the mental health needs of youth. This battery of standardized, self-report psychological screening instruments are currently administered to all youth, with results being reviewed by mental health staff for the development of treatment plans, and as a basis for identifying areas for further, more detailed assessment. This screening process may be revised, in consultation with the Court Expert and other nationally recognized experts.

The ITDCS is also developing policy and procedure for additional screening procedures specifically to identify cognitive disabilities in youth. Several screenings (K-BIT, WISC-IV, Vineland) could be administered to identify cognitive disabilities. This would be applied to youth not previously identified via the Individualized Education Plan (IEP) or documented Regional Center acceptance, as cognitively disabled. The Drug Experience Questionnaire (DEQ) is also a component of the TNA. The recently implemented Special Program Assessment Needs process is a more in-depth assessment tool designed to assess each youth required level of care. Indicators of mental health diagnosis or issues identified via the TNA process may result in a referral for a SPAN assessment.

Additionally, the DJJ is in the planning process with the Center for the Promotion of Mental Health in Juvenile Justice, with plans to implement the Voice Diagnostic Interview Schedule for Children – V-DISC as part of an overall assessment protocol. This additional mental health screening and assessment instrument will provide additional information on diagnosis, emergent risk issues, evidence-based treatment interventions for identified needs, and can also provide data for trend analysis, population review, bed utilization, etc. The V-DISC is also seen as a tool that could perform duties currently done by psychologists, freeing staff to provide more direct services. The implementation of a more inclusive screening and assessment protocol is a priority, and will be treated as an immediate need for the ITDCS.

The Initial Case Review (ICR) is currently conducted on all youth prior to leaving the reception center and clinics to begin their identified program. During the ICR, all intake, assessment and referral information is reviewed and the youth's Individual Change Plan Part I (ICP) is developed. This information is documented in the youth's file, and once received at the program, is documented in the Ward Information Network (WIN) by the assigned staff. The ICP is available to all members of the youth's Interdisciplinary Treatment Team (IDTT) for review and implementation. Changes to this process are outlined in the Safety and Welfare Plan.

All youth will be screened for emergent mental health issues within twenty-four hours of arrival, and referred for further assessment when indicated. Although the development of a more inclusive and research-based assessment protocol will be developed as part of the DJJ's remedial efforts, youth identified as requiring mental health services will have their needs met in a timely manner. When youth are identified as requiring mental health services or programs not available at a Reception Center and Clinic, the case shall be identified as requiring expedited processing that will be completed within fifteen working days. The Senior Psychologist at the Reception Center and Clinic will arrange for services to be provided in the interim.

Family and guardians are an essential part of the intake and assessment process. The assigned case manager is currently expected to make a family or guardian contact to complete the Clinic Summary report. As the new risk/needs assessment is implemented (per the Safety and Welfare Plan), it is anticipated staff will complete a family assessment domain as part of the integrated assessment process. Family and guardians can provide historical information essential to completing an accurate and complete psychosocial history, developing treatment plans, providing mental health information including medication history, etc. Throughout the youth's treatment, mental health staff must maintain contact with family and guardians for issues related

to consent for medical treatment and transition planning. Ongoing interaction and involvement of family, staff and youth will be an area of ongoing development for the DJJ.

SUBSTANCE ABUSE TREATMENT

Currently, the Division of Juvenile Justice (DJJ) provides substance abuse treatment for youth that are identified as requiring such services through the administration of the Drug Experience Questionnaire (DEQ). One program is a 120-day program specifically designed to treat parole violators. The others (at various facilities) are 180-day, gate (i.e. delayed admission until proximity to release) programs with entrance criteria based on the Severity Score of the DEQ and the proximity of the youth's Projected Board Date. There is a significant percentage of youth who require treatment in this area, and the division has identified the existing population requiring services. These youth will be included in the newly designed classification system, outlined in the Safety and Welfare Remedial Plan.

The SATP utilizes the Therapeutic Community model of treatment, and each youth's program is based on a standardized curriculum. Youth continue to attend school, vocational training or work, ensuring they are developing skills they will require when they transition back to the community. Youth Correctional Counselors deliver the standardized curriculum and mental health services are provided on an as needed basis by Core Program Outpatient Services (CPOS) addressing any mental health issues that become apparent. When and if a youth is diagnosed with a co-occurring disorder, the youth's mental health issues may become the focus of treatment, and the psychologist will assess the youth for a possible change in level or care, or provide the required mental health services while maintaining the youth in the SATP.

In the mental health treatment programs, youth with dual diagnoses will be identified and provided treatment services as appropriate. As mentioned previously, mental health diagnosis and identified level of care status will drive placement in these cases. Specific training about alcohol and substance abuse will include mental health professionals who are assigned to residential programs (including sex offender), in addition to training on co-occurring disorders.

QUALITY ASSURANCE AND PEER REVIEW

Health Care Services, as identified in the Medical Remedial Plan, developed a Quality Assurance and Peer review process to ensure that appropriate evidence-based mental health services are delivered by licensed, credentialed and trained professionals. Health Care Services, which includes mental health professionals, is developing internal quality management procedures which include administrative oversight, multi-disciplinary medical staff committee review, audits, training, standardization of policies and procedures and contracting with community agencies and universities for training and peer review. Concerns such as medical practice review, decision on medication management, audits and record reviews will be addressed under the supervision of the Health Care Services administration.

Training of staff, as previously mentioned in the "Training" section, will constitute a major component of the quality assurance issues within HCS. More detailed review of the Medical Remedial Plan will provide specifics of this component. Utilizing universities, research institutes, community agencies as well as other state agencies as consultants and trainers have been underway. Health Care Services is continuing efforts to utilize joint research opportunities and tele-medicine to train staff, and plans to utilize these resources as a component of quality assurance are underway.

In mental health units, the Youth Correctional Counselor (YCC) is an identified member of the Interdisciplinary Treatment Team, and requires more intensive lclinical training and supervision to provide rehabilitative/treatment services. In this role, YCCs are mandated to attend all Case Conferences for the youth assigned to their caseload. Participation in these reviews will provide exposure to clinical staff and discussion of therapeutic concepts, and when combined with increasing mental health training opportunities, will add to the clinical development of the YCC class. This will be essential for counselors to be able to recognize behavioral changes (possibly connected to medication issues) and to support the treatment being provided by other members of the team.

Providing other ongoing venues for non-medical staff to gain experience and a better understanding of how treatment is provided is essential. Non-medical staff involved in treatment services will learn through example and modeling how to be a functioning component of residential programs services. Mental health professionals are mandated to attend and facilitate groups,. In mental health units,YCCs will be scheduled by the Senior Youth Correctional Counselor to monitor/co-facilitate psychotherapy groups, increasing the YCCs exposure to interventions in process for modeling and training purposes. Additionally, the Casework Specialist (MSW), Parole Agent and Senior Youth Correctional Counselor (SYCC) will co-facilitate community groups and attend one small group per week run by the YCCs, thus building more supervision, coaching and training into the YCCs service delivery. All efforts to build the IDTT concept on the mental health programs will also be implemented on core program living units to a less intensive degree. The program services being developed as a component of the Programmatic Model will be the primary focus of treatment on core program living units.

IV. SCHEDULE OF IMPLEMENTATION

The Mental Health Transition Team, in collaboration with other mental health professionals currently practicing in the facilities, was assigned the charge of developing the Mental Health Remedial Plan. The development of a schedule of implementation for the tasks identified in the plan is outlined below. Many of the identified tasks have been in progress, and are near completion. Many are dependent on the completion of other tasks, personnel hires, funding, etc. to be completed. The response of this section is structured similarly to that identified in the Health Care Services Delivery System, Medical Remedial Plan. With this in mind, the areas where HCSDS policy and procedure addresses mental health treatment services should be reviewed for more specific detail.

ADMINISTRATIVE AND CLINICAL LEADERSHIP

The Expert Report on Mental Health and Substance Abuse Treatment Services identified several areas of concern in this area requiring remediation, including:

- Establish an organizational structure that provides oversight in Health Care Services administration with the Chief Psychiatrist and/or Chief Psychologist for direct supervisory responsibility over all psychiatrists and psychologists;
- Separate the clinical and administrative oversight of mental health programs; and
- Create a table of organization for the delivery of Mental Health services.

The HCS Medical Remedial Plan has developed an organizational structure (see Health Care Services Remedial Plan) that delineates authority at the administrative and facility levels. As needs for new programs and duties are identified and defined, new classifications will be added to this structure. Job descriptions and duty statements are currently in revision or development. Program guides (in development) for each level of care will clearly delineate supervisory and clinical lines of supervision. Requests for new positions to ensure full implementation of mental health services as identified in the plan will be submitted for approval through the budget process, as necessary.

STANDARDIZED POLICIES AND PROCEDURES FOR MENTAL HEALTH CARE DELIVERY

Inclusive policies and procedures, which are standardized and focused on the integration of mental health services, and which clearly define the roles and responsibilities of professionals who implement them is the most essential component of the Integrated Treatment Delivery of Care System (ITDCS). As stated in the Health Care Service (HCS) Medical Remedial Plan, polices drive the identification of required resources and the evaluation of outcomes. They also play an essential role in the success of any Quality Management and/or Peer Review programs. Policies, procedures and treatment guidelines (as defined in the program guides) will be reviewed by the Mental Health Expert prior to implementation.

The Mental Health Transition Team has begun to review, revise and identify the need for new mental health policy. With the hiring of mental health administrative personnel (, a complete set of essential policies will be identified and developed to both form the basis of the delivery of services and to address the deficiencies identified in the Expert's Report. All policies related to mental health services, as with health care policy, will be referenced to standards contained in the *Standards for Health Services in Juvenile Detention and Confinement Facilities*, and the more specific *Correctional Mental Health Care Standards & Guidelines for Delivering Services* by the National Commission on Correctional Health care, 2003 and 2004 editions. The Transition team will work closely with the Court Experts to develop policies and procedures.

Policy development will be based in the guiding principles and key concepts identified in this plan. Once the list of essential policies has been identified, procedures for the development, review, training and implementation of mental health policies will generally follow the steps below:

1. Drafts of policies will be developed by the Mental Health Transition Team and/or Mental Health administrators and forwarded to local facility personnel for review.
2. When appropriate, feedback will be incorporated into policy revisions.
3. Final drafts will be processed through the Policy, Procedures, Programs & Regulations Unit (PPPR) review process and will be promulgated.
    a. Policies needing immediate implementation will be processed as a "Temporary Departmental Order" (TDO) pending the internal review process and union negotiations.
4. Approved policies will be forwarded to local facility personnel to draft operational procedures specific to their facility that will ensure the appropriate implementation of the policy.
5. Operational procedures will be reviewed, edited as required, and approved by HCS administration for implementation.
6. Once operational procedures are approved, facility mental health administration will develop and implement staff training, document completion of training, and forward such to HCS administration.

Specific timelines for the completion of all required steps in the implementation of policy and procedure implementation to date are as follows:

- List of essential policies will be identified, drafted, sent to facilities for review and forwarded to the PPPR Unit for the review process by March 1, 2006.
- Once approved, policies will be forwarded to local facilities for the development of operational procedures on an ongoing basis, and will be completed within thirty days of receipt.
- Facility operational procedures will be reviewed by HCS administration within thirty days of receipt, and if adequate, will be approved for implementation.
- Training on the policy and operational procedures will be developed and completed by facility staff according to the following timelines:
    - Existing staff will be trained within **60 days** of approval of specific policy operational procedures.

- New staff will be trained within **30 days** of hire on appropriate policies and operational procedures.

STAFFING, EQUIPMENT AND SPACE

The Transition Team assigned to develop the HCS Medical Remedial Plan conducted site visits of every facility to form a baseline assessment of staffing, equipment and space. The tool utilized included the following items specific to mental health:

- Space for confidential, safe treatment services to be delivered;
- Appropriate office space, equipment and location;
- Computer access (with internet);
- Personal phone line;
- Current staffing levels and staff deployment.

Availability of confidential, safe space to provide mental health screening, assessments and treatment services is essential. Confidentiality is a benchmark in mental health treatment, as it supports trust and is ethically mandated of licensed mental health staff. The need for "mental health clinics" to provide confidential treatment space has been identified by the DJJ, and in addition to the existing plan to build three such clinics, further need for treatment and office space is being addressed in the long-term by facilities planning.

As part of the institution review of the policies and the development of local operating procedures, each institution evaluated their staffing, equipment and the space needs for each policy and report this information to the Transition Team. The Team used this analysis, coupled with the information contained in the experts' report, along with the results of the site visits to make recommendations to the department for required resources to implement the policies. These recommendations are currently under review. DJJ will provide staff, equipment and space that are adequate to meet the requirements of this plan and policies and procedures.

QUALITY MANAGEMENT AND PEER REVIEW PROGRAM

As stated in the HCS Medical Remedial Plan, Quality Management in a health care organization represents what is done and how well it is done. The goal is to accurately understand the basis for current performance so that better results can be achieved through focused improvement actions. The HCS Medical Remedial Plan provides a detailed description of several essential components of the Quality Management Program being developed by the HCS. In that mental health professionals are considered medical staff (licensed), these staff will be included in the same Quality Management Program. *A thorough review of the HCS Medical Remedial Plan is recommended.*

A specific component of the quality management program for mental health services is peer review. Audits and performance measurements are designed to support performance improvement and demonstrate accountability. These processes will assist in organizational

performance measurement and produce essential data for corrective action planning. Peer review for mental health professionals will bring to the ITDCS qualified "peer" professionals who, in addition to examination of records and care provided, can encourage, coach and critique the services provided to mental health staff.

IMPLEMENTATION OF TRACKING SYSTEM

As in the HCS Medical Remedial Plan, to ensure that the implementation of all aspects of the Mental Health Remedial Plan is being completed according to established timelines, a detailed Gantt chart will be developed and maintained by HCS and administrators in mental health. This chart will be updated on a continuous basis and modified as necessary when additional areas of concern are identified.

IV. STANDARDS AND CRITERIA

The Mental Health Remedial Plan calls for the implementation a number of changes and additions to the services provided to mental health youth. To monitor these changes, audit instruments with thresholds of compliance, credentialing requirements for mental health professionals, quality management reports and logs of activities, and peer review policies are in development.

The provisions of the Health Services Medical Remedial Plan concerning standards and criteria developed by the Court Experts apply also to this Plan. To measure DJJ compliance with the requirements of the Mental Health Remedial Plan an audit instrument with clearly defined standards, criteria and thresholds of compliance will be developed by the Court Experts. The audit instrument will be completed by March 15, 2006. The audit instrument will be comprised of indicators selected from:

- The Mental Health Remedial Plan;
- Policies and procedures approved by Court experts;
- National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Juvenile Detention and Confinement Facilities, 2004 Edition;
- The American Medical Association's Guidelines for Adolescent Preventive Services (GAPS);
- US Preventive Services Task Force (USPSTF), and
- Guidelines for the evaluation and treatment of other disease such as those published by the Centers for Disease Control and Prevention (CDC).

Regarding those areas related to nursing and medical care practice, Court experts will use the professional judgment to assess compliance.

AUDIT INSTRUMENTS WITH THRESHOLDS OF COMPLIANCE

The development of audit instruments with thresholds of compliance for areas of operation and care are spreadsheets that will be utilized by the HCS Quality Management Team and each facilities Quality Management Manager. The prioritization of audits to be conducted will be completed by HCS administration and the Chief Medical Officer (CMO) of each facility. On a quarterly basis, all mental health (and related medical) audit instruments will be completed according to identified priority. The list of identified areas of operations and care will include:

a) Documentation: Medical Records Review
b) Medicine Administration Record Review
c) Outpatient Housing Unit Care
d) Reception Center Assessment
e) Continuity of Care for Youth Transferred Between facilities
f) Restraints
g) Mental Health Treatment of Seriously Mentally Ill Youth
h) Seriously Mentally Ill Youth in Segregation
i) Discharged Seriously Mentally Ill Youth

j) Transfer of Seriously Mentally Ill Youth
k) Use of Psychotropic Drugs (specific audits for identified medication)
l) Serious Incident Reports of Mentally Ill Youth
m) Training Summary
n) Child Abuse Reporting and Investigations
o) Treatment Plan Development
p) Mental Health Assessment Protocols
q) Suicide and Self Injurious Behavior Statistics
r) Family Involvement
s) Community Transition Plans
t) Compliance with Acceptance and Rejection Criteria

The audit instrument will be used by both the Court experts, the Health Care Services Quality Management Team and by the local facility Quality Management Manager/ committee to evaluate progress consistent with the Remedial plan. The audit instrument will include indicators from sources cited above and those from the Mental Health Remedial Plan that Court experts judge to be critical to establishing an adequate health care system. Thresholds for achieving compliance may vary for selected indicators, and will be defined in accordance with paragraph 23 of the Consent Decree and by the Mental Health Expert. HCS administration and the Mental Health Expert will assess and develop appropriate standards for compliance in applicable areas.

The results of the audits will be presented to each facility Quality Management Committee and, when applicable, to the Subcommittees (Pharmacy and Therapeutics, Infection Control, Mental Health and Dental) for corrective action.

The facility Quality Management Team will develop Corrective Action Plans for each area that did not reach the target threshold level. Development of corrective plans will involve any facility staff that the committee feels may be necessary to create a viable plan. The plan will include an implementation section so that a review can assess how the corrective plan will be applied. A repeat audit will be conducted of the area in the next quarter or in cases where the plan may take longer to implement 6 months later. The appropriate Quality Management Committee will again analyze the results of the audit and if necessary another corrective plan devised. These reports of corrective action plans will be filed in a Quality Management file at the facility and sent to Health Care Services for review and storage in a Quality Management file. The Health Care Services may provide additional expertise to local facilities as needed to enhance corrective action plans.

CREDENTIALING FILES

Non-experts can also review credentialing files to determine if the appropriate documents are in each file. However, the non-expert reviewers may need help in learning to identify various documents.

QUALITY MANAGEMENT REPORTS AND LOGS

Several management reports and logs are developed or will be developed. Several of these are identified in the HCS Medical Remedial Plan. The reports indicate those which a non-expert can review the log and determine compliance. The list indicates the outcomes that are expected.

PEER REVIEW POLICIES

Developed within the context of the HCS Medical Remedial Plan, a peer review policy has been written and will be implemented. The reports completed on each practitioner will be available and include Physicians, Psychiatrists, and Psychologists. Each local facility and HCS administration will have reports available. The reports will chronicle the improvement plans for deficiencies found during the peer review. The Chief Medical Officer and solo practitioners will have their charts audited by CMOs from other facilities. The reviewer will look for improvement documented in subsequent audits of the practitioner.

QUALITY MANAGEMENT REPORTS AND LOGS OF ACTIVITIES FOR NON-EXPERT REVIEW

The HCS Medical Remedial Plan identifies numerous reports that can be reviewed by non-experts. As the need is identified in the audits and reports identified for mental health services, additional reports prepared in response to audits will be added to the following list:

1. Review reports of Health Care Services QM compliance coordinator with follow-up of corrective action.
2. Assessment of medical care/nursing care will be reviewable by reading threshold audit logs and monthly QM reports from facilities. Non-expert could review for compliance with the threshold printed on each audit item. An expert would have to review the correction plans. Discussed in narrative.
3. Review quarterly peer review and corrective plan for each physician or psychologist at each facility.
4. Records to be collected at Health Care Services. Discussed in narrative.
5. Review minutes of QM, Pharmacy Therapeutics, Infection Control and Dental QM committees from each facility. Discussed in narrative.
6. Review credentialing files. Non-expert may review but may need training in form recognition. Presence of required forms as per policy.
7. Logs documenting nursing competency in use of nurse protocols and initial training of new hires. Non-experts can determine presence of complete logs indicating training.
8. Review logs of staff education, planned education completed indicating education plans and completion.
9. Review list of training requested by staff and CME CEO training lists compared to 6.
10. Review log of sick call with date of request and date patient was seen. Non-expert may review. Determine length of waiting time to be seen.
11. Review formulary. Presence of juvenile-specific formulary.

12. Review some of daily physician prescribing lists and written review of lists by CMO-utilization management.
13. Review monthly drug utilization reports from each facility with minutes of pharmacy and therapeutic committee minutes regarding the utilization of drugs.
14. Review of logs of approved new positions based on projected staff requirements and review of log of newly hired staff. Non-expert may review. Compliance with staffing.
15. Review log of current staff with summary of vacancies. Non-expert may review.
16. Review job descriptions. Presence as required.
17. Review written policies and procedures. Presence as required.
18. Review of new intake screening form for appropriateness.

References:

1. *American Medical Association's Guidelines for Adolescent Preventive Services.* Chicago: American Medical Association. http://www.ama-assn.org/ama/pub/category/1980.html
2. *Standards for Health Services in Juvenile Detention and Confinement Facilities.* Chicago: National Commission on Correctional Health Care, 2004. http://www.ncchc.org
3. U.S. Preventive Health Services Task Force Guidelines